Submitting Paper Claims (CMS 1500)

Providers may continue to submit paper claims to DHMH for claims processing, but will experience longer processing times. Paper claims are generally paid within 4-6 weeks. Providers who choose to submit paper claims must use the CMS-1500 billing form and should send the forms to:

Department of Health and Mental Hygiene
Office of Systems, Operations, and Pharmacy
Claims Processing Division
P.O. Box 1935
Baltimore, MD 21203

Instructions for Completing the CMS-1500

Waiver for Older Adults providers are required to complete certain blocks on the CMS-1500 in order to receive payment. Table 1 shows all blocks that must be completed on the CMS-1500 form to receive payment for waiver services.

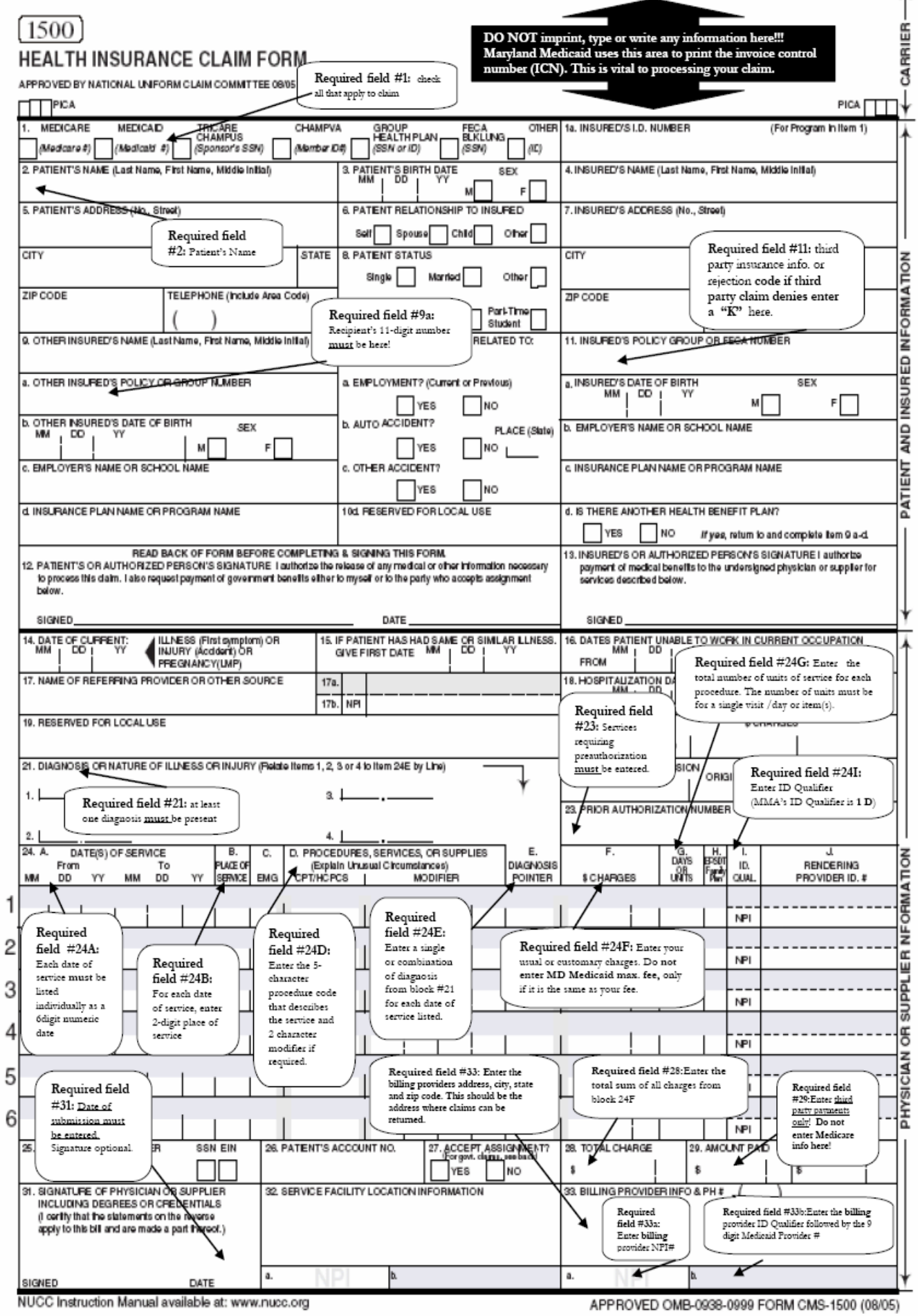
Remember:

- Always use the CMS-1500.
- Use one CMS-1500 form for each waiver participant.
- Be sure that the information entered on the form is legible.
- Be sure that the information entered is correct, especially when entering your Provider Number and the recipient's Medical Assistance ID number.
- Enter all information with blue or black ink.
- **Claims must be submitted within 12 months of the date of service.**

TABLE 1: Blocks to Complete on CMS-1500 for Billing Waiver for Older Adults Services

Block #	Title of Block	Required Entry
1.	Medicare/Medicaid/CHAMPUS/CHAMPVA/Group Health Plan/FECA Black Lung/Other	Check the box for Medicaid. Also, check the appropriate box(es) for any other type(s) of insurance applicable to this claim.
2.	Patient's Name	Enter participant's last name, first name, and middle initial from the Medicaid Assistance Card (e.g., Doe, John A).
9a.	Other Insured's Policy or Group Number [Participant's Medicaid ID number]	Enter the **participant's 11-digit Medical Assistance ID number** as it appears on the Medical Assistance Card. The Medical Assistance ID number **MUST** appear here, regardless of whether the participant has other health insurance.
11.	Insured's Policy Group of FECA Number	Insert Value **"K"** of the Maryland Medicaid Billing Instructions, in Block 11 of the CMS-1500.
21.	Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, or 4 to Item 24.E. by Line)	Participants are diagnosed as Other Specified Housing or Economic Situation; enter code "**V608.00.**"
24A.	Date(s) of Service From MM DD YY	Enter each separate date of service as a 6-digit numeric date (e.g. 07 01 07) for month, day, and year under the "**From**" heading. **Leave blank** the space under the "**To**" heading. Each date of service must be listed on a separate line. Ranges of dates **are not** accepted on this form.
24B.	Place of Service	For each waiver service, enter the appropriate place of service code: **11** for provider's office, **12** for participant's residence, **33** for assisted living or **99** for other facility.
24D.	Procedures, Services, or Supplies CPT/HCPCS	In the block for CPT/HCPCS, enter the 5-digit Medicaid procedure code for the waiver service (e.g., W0204).
24E.	Diagnosis Pointer	In the block for Diagnosis Pointer, enter the corresponding line number from Block 21 (e.g., 1, 2, 3, or 4).
24F.	$ Charges	Enter the **total** charge billed for the procedure code (not the cost per unit of service). Do not enter the maximum fee unless that amount is your usual and customary charge. If there is more than one unit of service on a line, the charge entered for this block should be the **total** for all units on this line.

24G.	Days or Units	Enter the number of units of service for each procedure. The number of units must be for a single device, visit, or job.
28.	Total Charge	Enter the sum of the charges shown on all lines for Block 24F.
31.	Signature of Physician or Supplier including Degree or Credentials [Degree]	**Enter the date the CMS-1500 was completed or submitted. A date must be placed in this field in order for the claim to be reimbursed.** Signature by the payee provider's authorized representative is optional. Signature by physician or supplier should include degree or credentials.
33.	Provider's Billing Name, Address, Zip Code, and Phone Number	Enter the name, street, city, and zip code to which the claim may be returned.
33a.	Provider's Medicaid Provider Number [National Provider Identifier]	**Your 9-digit provider number to which payment is made MUST be prefixed with a '5' in order for the claim to be reimbursed** (e.g., 5012345678)**.**
33b.	Provider's Medicaid Provider Number	**Your 9-digit provider number to which payment is made MUST be prefixed with a '1D' in order for the claim to be reimbursed** (e.g., 1D012345678).


1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05
DO NOT imprint, type or write any information here!!! Maryland Medicaid uses this area to print the invoice control number (ICN). This is vital to processing your claim.
Required field #1: check all that apply to claim
PICA
CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
Required field #2: Patient's Name
Required field #9a: Recipient's 11-digit number must be here!
Required field #11: third party insurance info. or rejection code if third party claim denies enter a "K" here.
Required field #21: at least one diagnosis must be present
Required field #23: Services requiring preauthorization must be entered.
Required field #24G: Enter the total number of units of service for each procedure. The number of units must be for a single visit /day or item(s).
Required field #24I: Enter ID Qualifier (MMA's ID Qualifier is 1 D)
Required field #24A: Each date of service must be listed individually as a 6digit numeric date
Required field #24B: For each date of service, enter 2-digit place of service
Required field #24D: Enter the 5-character procedure code that describes the service and 2 character modifier if required.
Required field #24E: Enter a single or combination of diagnosis from block #21 for each date of service listed.
Required field #24F: Enter your usual or customary charges. Do not enter MD Medicaid max. fee, only if it is the same as your fee.
Required field #31: Date of submission must be entered. Signature optional.
Required field #33: Enter the billing providers address, city, state and zip code. This should be the address where claims can be returned.
Required field #28:Enter the total sum of all charges from block 24F
Required field #29:Enter third party payments only! Do not enter Medicare info here!
Required field #33a: Enter billing provider NPI#
Required field #33b:Enter the billing provider ID Qualifier followed by the 9 digit Medicaid Provider #
NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)